

Benign renal tumours

Extremely common – esp. in females < 45 yrs

May arise from cortical tissue (adenoma/oncocytoma) or differing mesenchymal elements

Types:

- Benign renal cyst
- Renal cortical adenoma
- Metanephric adenoma
- Oncocytoma
- Angiomyolipoma
- Cystic nephroma
- Mixed epithelial stromal tumour of kidney (MESTK)
- Leiomyoma
- Others
 - Fibroma
 - Lipoma
 - Lymphangioma
 - Haemangioma
 - Juxtaglomerular tumour (reninoma)

Benign renal cyst

Commonest renal lesion – accounts for 70%

Male:female 2:1

Seen in 50% individuals over 50 yrs

Growth rate 2.8mm/yr (Terada 2002) – faster in young pts

Large symptomatic cysts may require Rx: percutaneous aspiration/sclerosis successful in 90% (Hanna 1996) using 95% alcohol. More recently laparoscopic decompression reportedly safe (Roberts 2001)

Renal cortical adenoma

Controversial diagnosis

Small tumours arising from renal cortex well documented. Post-mortem studies indicate incidence of 7-23% [incidence on USS screening much lower @ <1%; Tosaka 1990]. Typically well-circumscribed lesions with uniform cells and unremarkable nuclear features, usually arranged in tubulopapillary or papillary arrays. Bell reported low rate of metastasis (~5%) of such lesions when <3cm when compared with a rate of 66% for lesions >3cm (Bell 1938, 1950). Led to pervasive 3cm rule. However now generally believed that all solid epithelium-derived tumours potentially malignant. Reasons:

Increase with age

Male:female ratio 3:1

Associated with smoking

More common in VHL disease and acquired renal cystic disease

Commonly exhibit trisomy 7/17 (as in papillary RCC)

No histopathological distinction from RCC

Metanephric adenoma

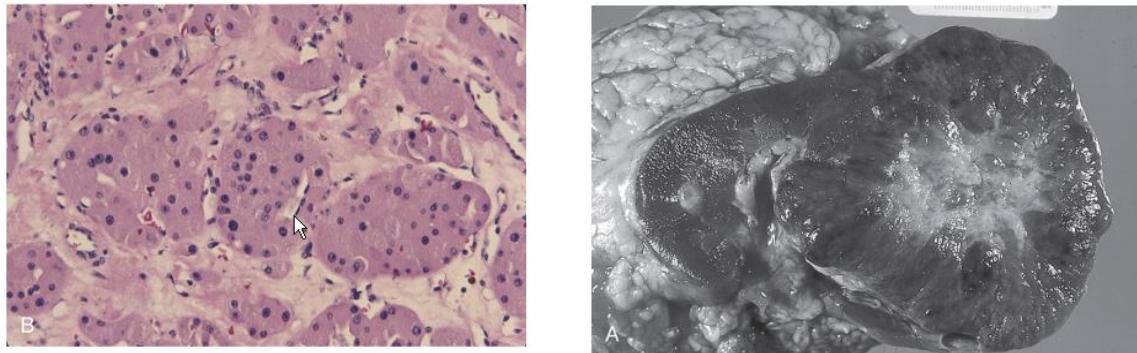
Rare renal tumour associated with benign clinical course

Usually incidental mass lesion requiring nephrectomy

Occasional presentation with flank pain, haematuria, mass, polycythaemia and hypercalcaemia
Microscopically characteristic – small cells intense basophilic staining resembling nephroblastoma (Wilm's tumour) – also positive for Wilm's tumour protein-1 with similar IHC characteristics and often regresses with scar/calcification.
Largest series Davis 1995: 44% symptomatic. Mean size 5.5cm. One case of metastasis described, although may be aggressive variants.
Follow-up post-nephrectomy uncharacterised due to rarity. Recommend follow-up as for low-risk RCC.

Oncocytoma

Originally described by Klein and Valensi 1976
3-7% of all renal masses
Almost universal benign growth
Mahogany brown tumour; well circumscribed but lacking true capsule
Central stellate 'scar', usually lacking fibrosis or hypervascularity
Uniform round, polygonal cells with dense eosinophilic staining and little cytological atypia. Derived from distal convoluted tubule.
Packed with mitochondria at ultrastructural level
A/w loss of chromosome 1 and Y; LOH on chromosome 14q and 11q13; typical chromosomal abnormalities associated with RCC (chr. 3,7,17) very rarely seen in oncocytoma
CT findings of central necrosis and stellate scar poor predictive value in differentiating oncocytoma from necrotic RCC (Licht 1995)
Difficult to differentiate from granular clear-cell RCC or eosinophilic chromophobe RCC on biopsy
Co-exists with RCC in 7-32% of cases [Campbells]. Therefore surgical treatment advocated – partial if strongly suspected (BHD and features) and favourable location.
Oncocytoma a/w multicentricity, bilaterality and metachronous recurrence in 4-13%. Intermittent USS surveillance therefore advocated by some.
Associated with Birt-Hogg-Dube syndrome and familial oncocytosis
BHD
 Short arm of chromosome 17 – codes for folliculin
 Hair follicle tumours
 Spontaneous pneumothorax
 Renal oncocytoma
Familial oncocytosis
 Genetic defect unknown
 Renal oncocytomas
 Multicentric
 Bilateral
 Early age of onset



Angiomyolipoma

Uncommon

0.3% incidence in post-mortem series; 0.1% in USS screening

Term first coined in 1951 by Morgan

80% sporadic; 20% a/w tuberous sclerosis [Autosomal dominant condition characterised by mental retardation (twits), epilepsy (fits), adenoma sebaceum (facial angiofibromas - zits), and ash-leaf patches]

Thought to be derived from perivascular epithelioid cells

Probably hormone (?oestrogen) dependent

More common in females

Extremely rare before puberty

Accelerated growth in pregnancy (increased risk of rupture)

Rapid growth associated with OCP usage

Presentation

Asymptomatic >50%

Loin pain

Haematuria

Anaemia

Massive retroperitoneal haemorrhage (Wunderlich's syndrome) 10%

Characteristics of AML by subtype

	Sporadic AML	AML in TS
Frequency	80%	20%
Male:female	1:4	1:2
Peak age	50 yrs	30yrs
Distribution	Unilateral single	Bilateral multicentric
Growth rate	<5% per year	20% per year
Symptoms	Usually asymptomatic	Often symptomatic

Radiological findings

USS Typical but non-diagnostic finding is a well-circumscribed highly echogenic lesion with acoustic shadowing (small calcified RCC rarely shadows on USS – Seigel 1996)

CT Most reliable diagnostic modality

Presence of fat (-20 HU) within the lesion on CT virtually excludes RCC* and considered diagnostic (Bosniak 1998)

* all 5 reported cases of RCC containing fat also contained areas of

calcification, which has *never* been reported in AML (Lemaitre 1997)
 Up to 14% of AMLs do not have identifiable fat and should be treated as RCC until proved otherwise

MRI Fat-suppressed images may be helpful in difficult cases or when CT contraindicated for other reasons
 Angio 50% AMLs a/w aneurysmal dilatation

Clinical behaviour

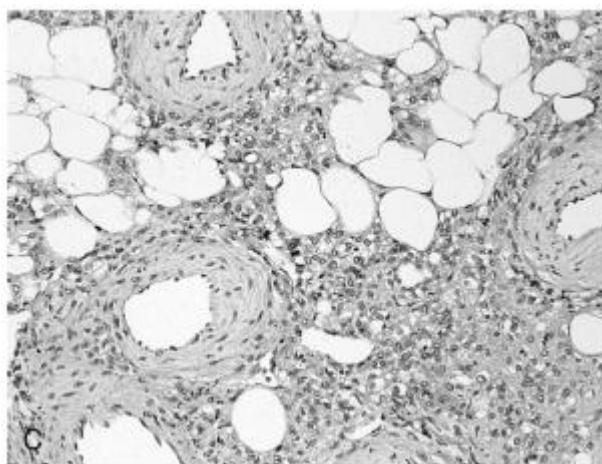
Universally benign

Non-renal AMLs found in LN, retroperitoneum and even into renal vein reported but thought to be due to multicentricity rather than metastasis
 Occasionally cellular atypia identified and differentiating from sarcoma may be difficult (fat = liposarcoma; smooth muscle = leiomyosarcoma; vascular – fibrosarcoma). In such instances positive staining for **HMB-45** (monoclonal antibody vs. melanoma-associated antigen) highly specific for AML rather than sarcoma

Recently an epithelioid variant of AML has been described which displays pathologic features associated with aggression in a number of other cancers (necrosis, nuclear atypia and mitosis) and is reportedly associated with metastasis (Bissler 2004). However, a recent large multicentre retrospective series including the Cleveland Clinic reported on 15 cases of epithelioid AML with long term follow-up (mean 5.1 years). Despite unfavourable pathology, none had local recurrence or distant metastases (Aydin 2008).



Bilateral AML in TS



Fat, smooth mm., thick-walled BV

Despite benign behaviour AMLs may be life-threatening due to rupture
Risk of rupture related to size: multiple studies have shown that AMLs >4cm
a/w symptoms and an increased risk of rupture (most studies broadly agree
with findings of Oesterling 1986

<4cm 20% symptomatic
>4cm 80% symptomatic (9% acute rupture)

Growth rates (combined figures from Steiner 1993, Kenelly 1994, DeLuca
1999)

<5cm only ~8% show interval growth
on extended follow-up. Other than TS, no reported
specific factors to identify which tumours will grow

Management

Surveillance recommended for asymptomatic lesions < 4cm. Interval imaging
at 6 months or 12 months to determine growth rate. No studies defining when
discharge safe for stable tumours.

Intervention considered for:

Large tumours > 4cm

Symptomatic tumours

Women contemplating pregnancy in whom emergency intervention
would be difficult or undesirable

NB. For patients with TS, bilateral or multicentric tumours, or renal
insufficiency should be considered for NSS

Transarterial selective embolisation

Currently considered modality of choice

Originally reserved for patients with TS: recent large series confirm safety and
efficacy in all AMLs

Largest single study to date Ramon 2008 (Israel): 48 AMLs embolised with
polyvinyl alcohol and particles. Mean tumor size 10.3cm. Successful SAE in
91% with surgery avoidance in 96%. Minor complications in 11%. Post-
embolisation syndrome in 12.5%. 5 yr follow-up = no deaths, no RP
haemorrhage, no deterioration in creatinine, 98% renal preservation. Older
combined series report reduced efficacy, with re-treatment rates of
approximately 15% (Harabayashi 2004)

Overall complication rate from combined series 10%:

Groin complications (bleed, haematoma, infection)

Post-op haemorrhage

Post-embolisation syndrome (fever, loin pain)

Abscess formation

Cyst formation

Failed embolisation

Alternative treatments

Partial nephrectomy

Simple nephrectomy

Radical nephrectomy (if diagnosis in doubt)

Tuberous sclerosis

Described by Bonneville in 1880

Incidence 1:6000 – 1:14500

TSC1 gene on chromosome 9q

TSC2 gene on chromosome 16p (adjacent to PKD1 gene)



Figure: increased vascularity/aneurysmal dilatation

Cystic nephroma

AKA multiloculated cystic nephroma – now reclassified as RESTs (renal epithelial-stromal tumours)

Benign tumour

Bimodal age distribution: 2-3 yrs; 30-50 yrs

Commoner in male children and adult females

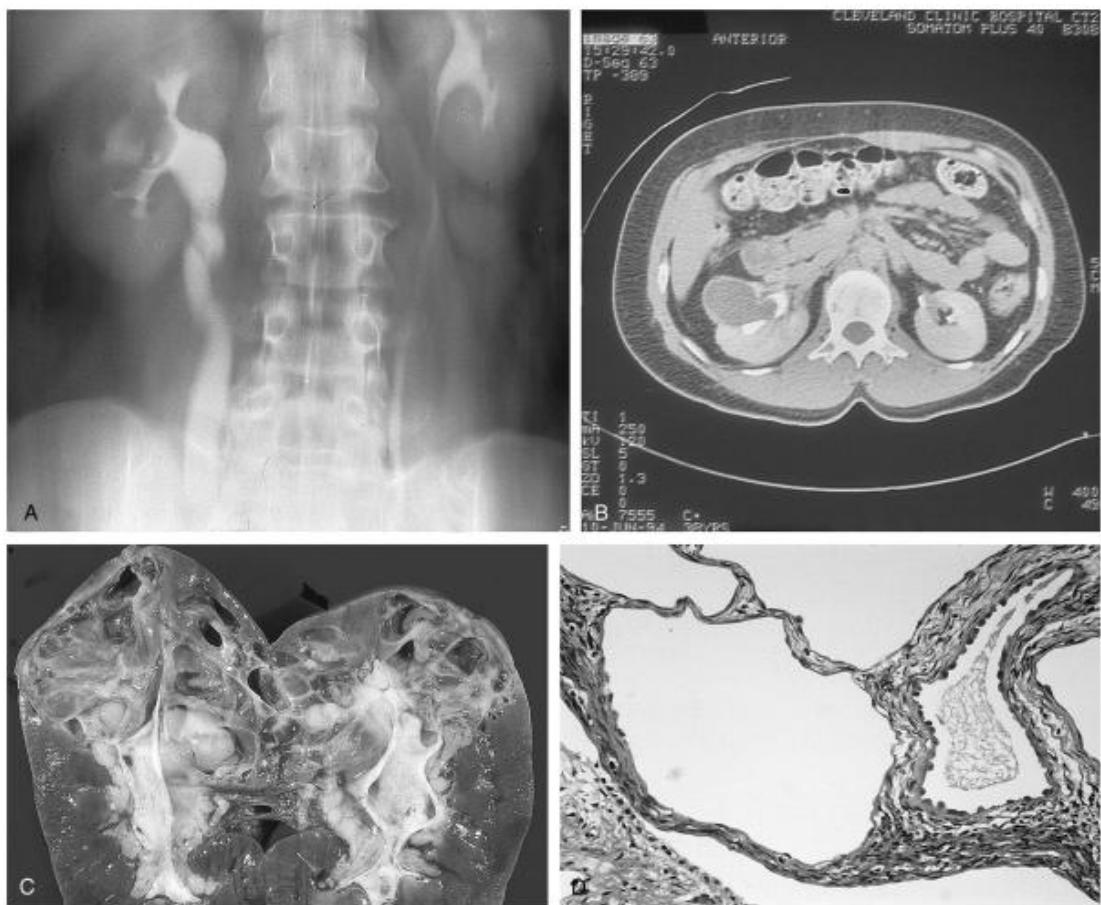
Macro: well circumscribed, encapsulated, multiloculated with intervening septa

Micro: cuboidal cells lining cysts with hobnail appearance

Asymptomatic in kids; haematuria, pain, hypertension in adults

Virtually all have appearances of Bosniak III/IV cysts on imaging – therefore usually post-surgery finding. May be suspected by finding of curvilinear calcification and herniation into renal pelvis

If suspected on imaging - partial OK in adults; radical nephrectomy in kids as differentiation from cystic Wilm's tumour difficult



A, Intravenous urogram demonstrates indentation of the midportion of the right renal pelvis, suggesting a mass effect. **B**, CT scan reveals a multiloculated cystic mass herniating into the collecting system. **C**, Nephrectomy specimen harboring a multiloculated mass that protrudes into the collecting system. **D**, Cystic nephroma illustrating diagnostic findings: multiple cysts lined by hobnail-shaped epithelial cells and intervening stroma notable for increased cellularity.

Mixed epithelial stromal tumour of the kidney

Recently described (Adsay 2000)

Usually in perimenopausal women taking oestrogen therapy

Positive staining for oestrogen and progesterone receptors

Solid and cystic components – appearance similar to cystic nephroma macroscopically. Bosniak III/IV on CT.

Benign clinical course after radical nephrectomy in all 12 patients described by Adsay

Leiomyoma

Arise from capsule, peri-pelvic tissues, or rarely renal vein

Incidence of ~5% in post-mortem series

Vast majority asymptomatic. Occasionally grow to a large size causing pain, haematuria or gastric complaints [largest resected lesion 57cm, in diameter!]

Mx – surveillance if asymptomatic and obvious; partial if symptomatic and suspected. Radical otherwise

Other renal tumours

Fibroma - small medullary 1-7mm in diameter. Rarely symptomatic. 10 clinical cases in literature usually presenting with filling defect

Lipoma – Arise from renal capsule. Occasionally confused with AML.

Lymphangioma – cavernous tumour, females in 30s

Solitary fibrous tumour – DD fibrosarcoma – WLE advised

Juxtaglomerular tumour (aka reninoma)

Females 20-40 yrs

Derived from endothelial cells – therefore positive staining for factor 8

Small (<3cm) solid tumours easily seen on CT/USS

Present with high BP, low K+, polydipsia, polyuria, headache

Surgical excision curative